

ONTARIO HEALTH SECTOR

An Updated Assessment of Ontario Health Spending

Winter 2018

About this Document

Established by the *Financial Accountability Officer Act, 2013*, the Financial Accountability Office (FAO) provides independent analysis on the state of the Province's finances, trends in the provincial economy and related matters important to the Legislative Assembly of Ontario.

The FAO produces independent analysis on the initiative of the Financial Accountability Officer. Upon request from a member or committee of the Assembly, the Officer may also direct the FAO to undertake research to estimate the financial costs or financial benefits to the Province of any bill or proposal under the jurisdiction of the legislature.

This report was prepared on the initiative of the Financial Accountability Officer. In keeping with the FAO's mandate to provide the Legislative Assembly of Ontario with independent economic and financial analysis, this report makes no policy recommendations.

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Table of Contents

1 	Essential Points	1
2 	Introduction	5
3 	Health Sector Expense Trends	9
	New health sector spending in the 2017 budget	9
	2017 budget health sector expense growth rates by program area	11
4 	Health Care Cost Drivers and Health Sector Expense	13
	Health care cost drivers	13
	Core cost drivers and health sector expense in the medium-term	14
	How does the Province plan to continue restraining the growth of health spending to below its core cost drivers?	16
5 	Federal Support for Ontario Health Spending	19
6 	Appendices	21
	Appendix A: Ontario health sector expense data by program area	21
	Appendix B: Development of this report	25

Table of Abbreviations

Abbreviation	Long Form
CHT	Canada Health Transfer
CIHI	Canadian Institute for Health Information
FAO	Financial Accountability Office
MOHLTC	Ministry of Health and Long-Term Care
OHIP	Ontario Health Insurance Plan
OMA	Ontario Medical Association
TBS	Treasury Board Secretariat

1 | Essential Points

This report provides an updated assessment of the Province's health sector expense plan in order to support Members of Provincial Parliament in evaluating health sector spending in the upcoming 2018 Ontario Budget.

New health spending in the 2017 budget

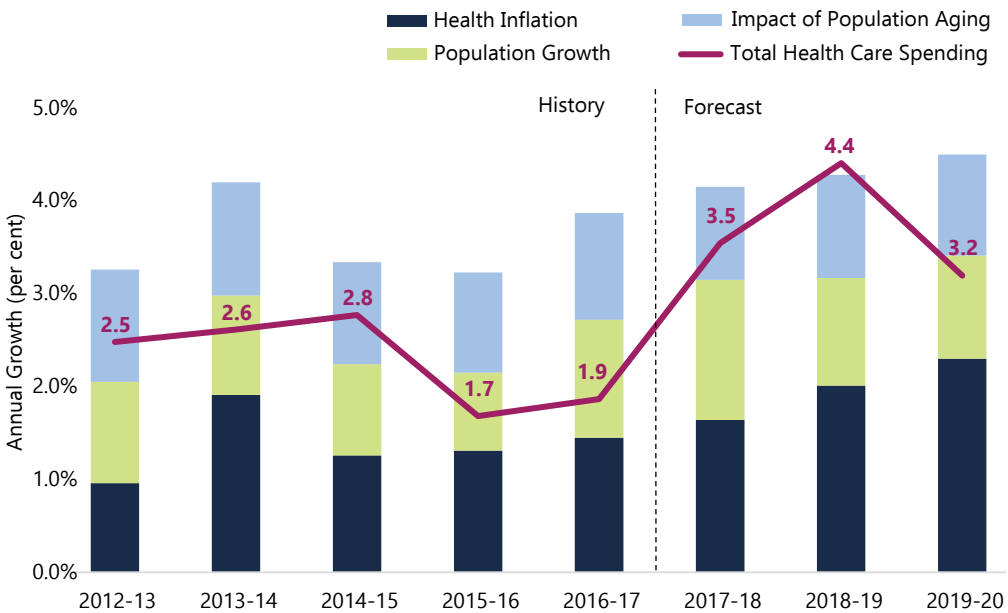
- In the 2017 Ontario Budget, the Province announced \$6.9 billion in new funding for the health sector. Of this new spending, \$1.0 billion (14 per cent) was allocated for 2017-18, with the remaining 86 per cent allocated to 2018-19 and 2019-20.
- Of the \$6.9 billion in new funding, \$5.7 billion is an increase in spending on health care services, while the remaining \$1.2 billion reflects an accounting adjustment to the Healthcare of Ontario Pension Plan, and does not involve any additional cash spending.
- Based on the FAO's review of the \$5.7 billion in new health services spending, \$4.2 billion is additional funding for existing programs, while \$1.5 billion is funding for new programs (mainly the introduction of OHIP+).

Health care cost drivers and health sector spending

- Population growth, population aging and price inflation are three core drivers of health care costs.* From 2011-12 to 2016-17 health sector spending growth was consistently slower than the growth in its core cost drivers. Even with the additional health care funding in the 2017 budget, health sector spending is only projected to out-pace the growth of health care cost drivers in a single year – 2018-19.

* There are other factors that influence health care costs, including: the introduction of new health care services (or the removal of old ones), the adoption of new technologies and medications, efficiency measures, rising incomes, government policies, and the underlying health of the population.

Health spending is growing slower than its core cost drivers every year except 2018-19



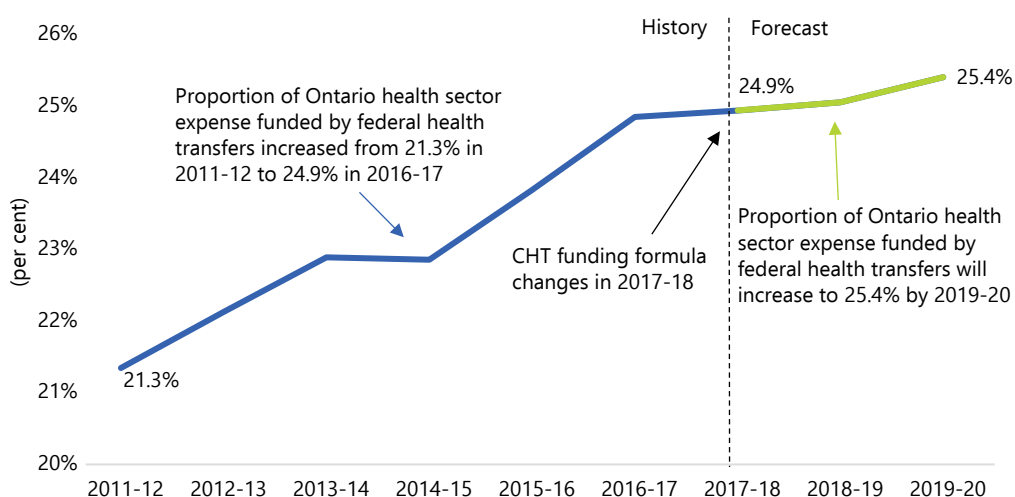
Source: 2017 Ontario Economic Outlook and Fiscal Review, and FAO analysis of data from MOHLTC and TBS.

- Since 2012, the Province has restrained the growth of health sector spending primarily by: imposing a four-year freeze in base operating funding to hospitals, increasing hospital efficiency, and restraining wage growth in the health sector. Going forward, it is not clear to what extent the Province can continue to rely on temporary measures, such as wage restraint, to limit health sector spending growth to below the growth in its core cost drivers. Unless the Province can continue to find significant efficiencies, there is a risk that additional spending will be required to avoid reductions in health care access or quality in the coming years.

Federal support for Ontario health spending

- The federal government's Canada Health Transfer has been funding an increasing share of Ontario's health sector spending, rising from 21.3 per cent in 2011-12 to 24.9 per cent in 2016-17.
- In 2017-18, the Canada Health Transfer funding formula was changed, reducing the growth of federal health transfers going forward. Even so, the revenue from federal health transfers will continue to grow faster than Ontario's planned health sector spending, with the result that federal transfers will continue to fund an increasing share of the Province's health sector spending from 2017-18 to 2019-20.

Federal health transfers will continue to fund an increasing share of Ontario's health spending

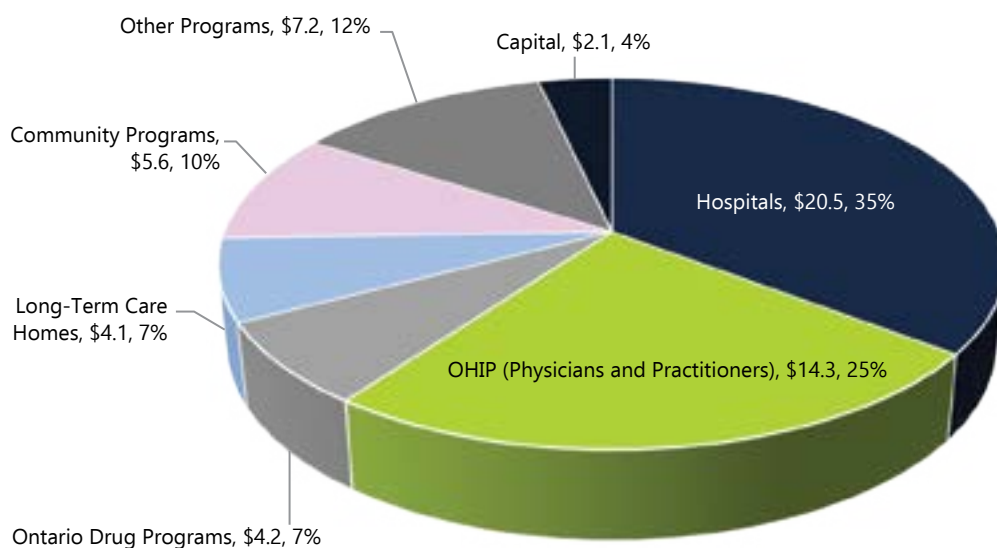


Source: FAO and analysis of data from MOHLTC and TBS.

2 | Introduction

The health sector is the largest expense item in the Ontario budget. The 2017 Fall Economic Statement projects \$57.9 billion of health sector expense in 2017-18, comprising 42 per cent of total program spending.¹ The Province divides the health sector into seven program areas. The two largest program areas are hospitals and the Ontario Health Insurance Plan (OHIP), together accounting for \$34.8 billion or 60 per cent of health sector expense in 2017-18.

Health sector expense by program area, 2017-18 (\$ billions)



Source: FAO analysis of data from MOHLTC, TBS and the 2017 Ontario Economic Outlook and Fiscal Review.

From 2005-06² to 2011-12, health sector expense in Ontario grew by an average of 5.9 per cent annually. However, after the 2008-2009 recession, limiting the growth of health sector spending was a critical part of the Province's plan to achieve a balanced budget in 2017-18. From 2011-12 to 2015-16, annual health sector expense grew by only 2.4 per cent on average.

¹ 2017 Ontario Economic and Fiscal Review, page 126.

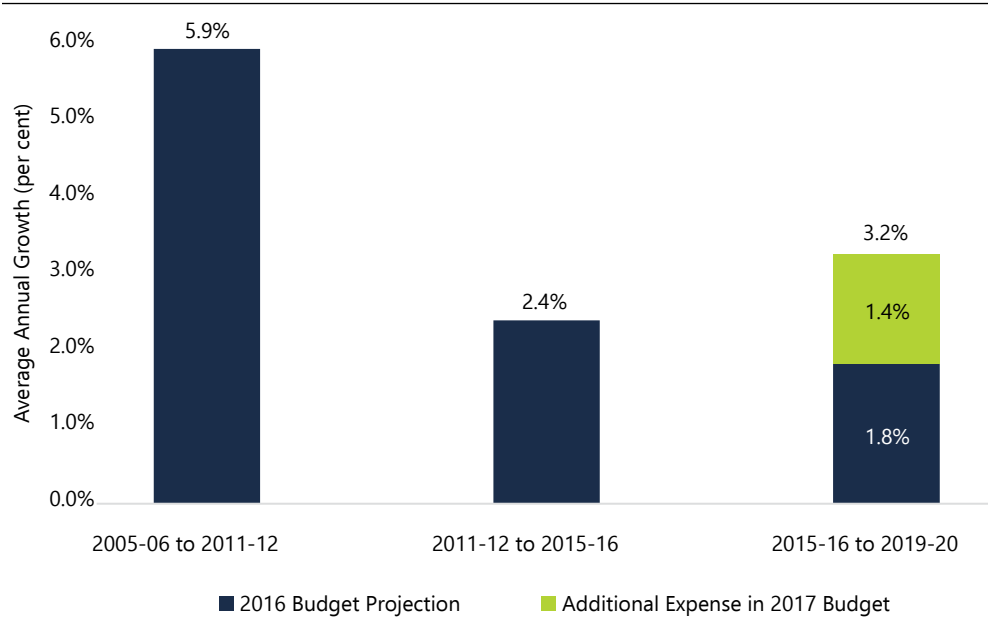
² Health spending data was restated in the 2017 Ontario Economic and Fiscal Review to include third party revenue for hospitals explicitly. 2005-06 is the earliest available year of health spending data on a comparable basis.

In the 2016 Ontario Budget, the Province projected 1.8 per cent average annual growth in health sector expense during the 2015-16 to 2019-20 period.³ This would have been slower than the 2.4 per cent average annual growth rate of the previous four years, and substantially slower than the 5.9 per cent average annual growth rate during the 2005-06 to 2011-12 period.⁴

In January 2017, the FAO released the report: *Ontario Health Sector: Expense Trends and Medium Term Outlook Analysis*, which reviewed the Province’s plans to achieve the 2016 budget’s health sector expense targets. Two of the report’s key conclusions were that the Province reduced health sector expense growth starting in 2012-13, primarily by slowing spending growth in the hospitals and OHIP program areas, and that additional expense savings would be required to achieve the 2016 budget targets.

However, in the 2017 Ontario Budget, the Province announced an additional \$6.9 billion in health sector spending from 2017-18 to 2019-20. This raised the planned annual growth rate of Ontario’s health sector from 1.8 per cent to 3.2 per cent during the 2015-16 to 2019-20 period.

Ontario health sector expense: average annual growth rates



Note: 2016 budget projection does not include 2016-17 actual, as it was not available at the time.

Source: FAO analysis of data from MOHLTC, TBS and the 2016 and 2017 Ontario Budgets.

³ According to FAO analysis of the 2016 Ontario Budget and information provided by MOHLTC.
⁴ For more on historical health sector expense, see the FAO’s [Ontario Health Sector: Expense Trends and Medium Term- Outlook Analysis](#).

The purpose of this report is to provide an updated assessment of the Province's health sector expense plan in order to assist Members of Provincial Parliament in evaluating health sector spending in the upcoming 2018 Ontario Budget.

This report:

- analyzes how the additional health sector spending from the 2017 budget will be allocated across program areas, and how it will affect program area growth rates;
- compares the Province's projected health sector expense growth to the FAO's projections of medium-term health care spending cost drivers; and
- examines how the federal share of health care funding has evolved in Ontario, and how it may evolve in the future.

Appendix B provides more information on the development of this report.

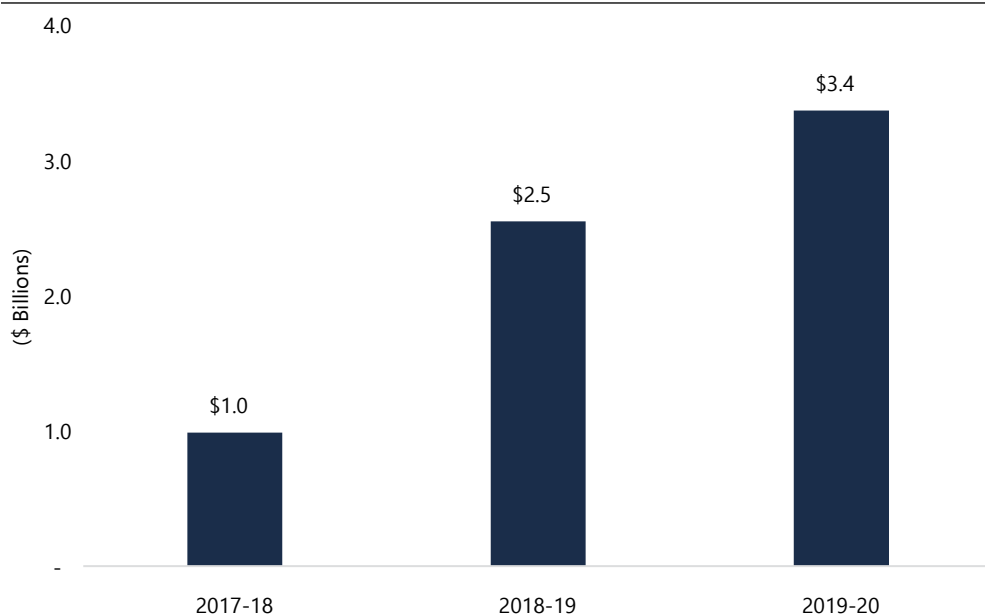
3 | Health Sector Expense Trends

The 2017 Ontario Budget announced that “the government is investing an additional \$7 billion in health care over the next three years, compared to the 2016 budget plan, to reduce wait times, improve access to care and enhance the patient experience.”⁵ This chapter explores how this new funding will be spent, and how it will impact the growth rates of health sector program areas when compared to the 2016 budget plan.

New health sector spending in the 2017 budget⁶

The 2017 Ontario Budget included \$6.9 billion in cumulative new health sector funding over the three-year period from 2017-18 to 2019-20, when compared to the 2016 budget plan. Of this new expense, \$1.0 billion (14 per cent) is allocated for 2017-18, with the remaining 86 per cent allocated to 2018-19 and 2019-20.

Allocation of the \$6.9 billion in new health sector expense by fiscal year



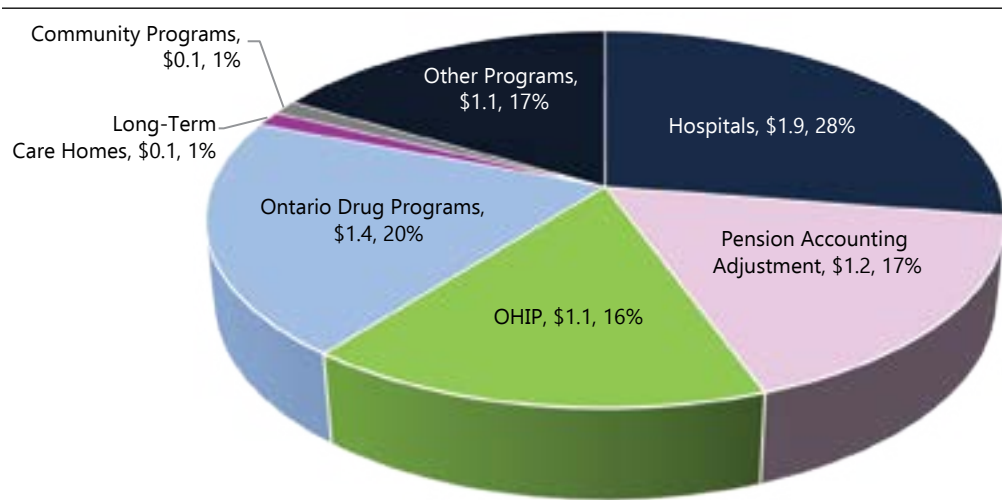
Source: FAO analysis of the 2016 and 2017 Ontario Budgets.

⁵ 2017 Ontario Budget, page 105.

⁶ The health spending numbers in this report are consistent with the accounting presentation in the 2017 Ontario Economic Outlook and Fiscal Review, which did not announce any additional health sector spending from the 2017 Ontario Budget.

The FAO reviewed how the \$6.9 billion in new health sector expense was allocated by program area. Importantly, \$1.2 billion of the new health sector expense represents an accounting adjustment to the Healthcare of Ontario Pension Plan (HOOPP), which does not involve any additional cash spending. As a result, only \$5.7 billion is new spending on health services.

\$6.9 billion additional health sector expense by program area from 2017-18 to 2019-20 (\$ billions)



Source: FAO analysis of data provided by MOHLTC and TBS.

Of the \$5.7 billion in new health sector spending, 97 per cent was allocated to four program areas: hospitals, OHIP, Ontario Drug Programs and other programs. Some of the new health sector spending was allocated to existing programs, and some was used to fund new initiatives. In particular:

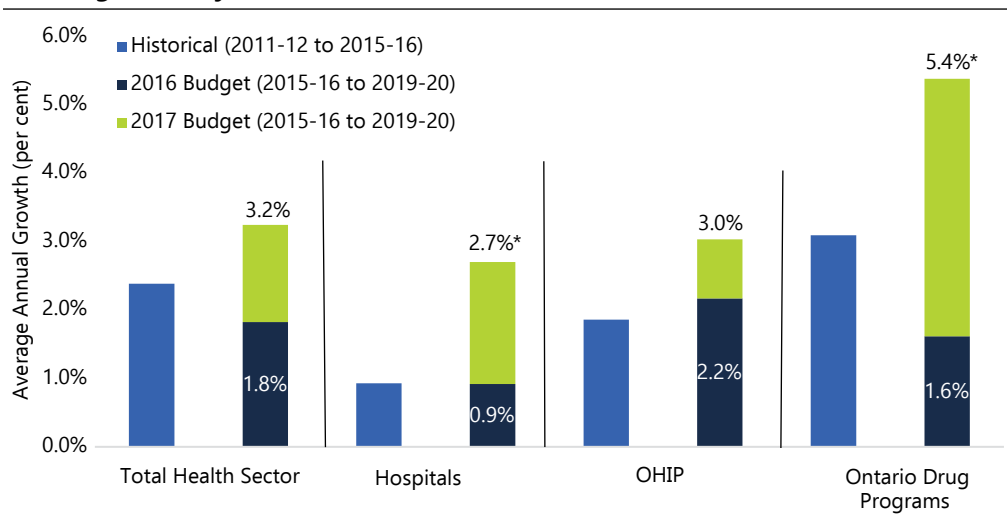
- The vast majority of the \$1.9 billion increase to hospitals is to fund existing programs.
- The \$1.1 billion increase to OHIP funding includes \$0.9 billion to fund existing programs, as well as \$0.2 billion to support the modernization of community labs.
- The \$1.4 billion in additional funding for Ontario Drug Programs includes \$0.5 billion of additional funding for existing programs, as well as \$0.9 billion to fund OHIP+, a new program expanding public insurance to cover the cost of prescription medicines for children and youth under age 25.
- The \$1.3 billion in additional funding for the remaining program areas includes \$0.9 billion to fund existing programs and \$0.4 billion to fund other new initiatives.

In total, the FAO estimates that of the \$5.7 billion in additional health sector spending, \$4.2 billion of this funding is being allocated to relieve pressures in existing programs, while \$1.5 billion is funding new initiatives (mainly the introduction of OHIP+).

2017 budget health sector expense growth rates by program area

As noted above, the new health sector spending announced in the 2017 Ontario Budget raised the projected average annual growth rate of health sector expense from 1.8 per cent to 3.2 per cent over the 2015-16 to 2019-20 period.

The 2017 budget raised planned expense growth in the largest health program areas significantly



*Hospitals expense includes the \$1.2 billion pension accounting adjustment. Ontario Drug Programs expense includes new funding for OHIP+.

Source: FAO analysis of data from MOHLTC and TBS.

The additional funding for hospitals, OHIP and Ontario Drug Programs addressed some of the spending restraint that had been in place since 2011-12, increasing planned expense growth from the 2016 budget plan.

- For hospitals, the 2017 budget raised planned average annual expense growth from 0.9 per cent to 2.7 per cent from 2015-16 to 2019-20.⁷
- For OHIP, the 2017 budget raised planned average annual expense growth from 2.2 per cent to 3.0 per cent from 2015-16 to 2019-20.

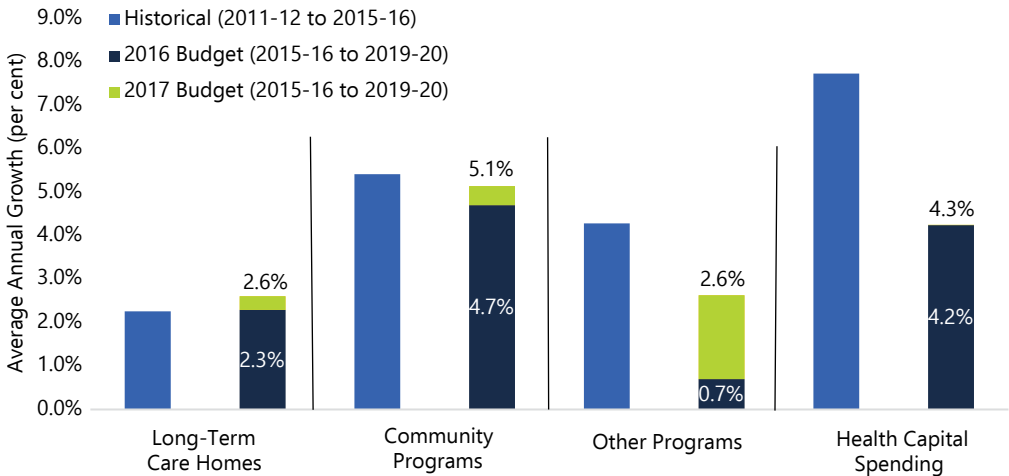
⁷ Excluding the \$1.2 billion pension accounting adjustment, hospital spending is forecast to grow by an annual average of 2.3 per cent over the 2015-16 to 2019-20 period.

- For Ontario Drug Programs, planned average annual expense growth increased from 1.6 per cent to 5.4 per cent, primarily due to the introduction of OHIP+. ⁸

The 2017 budget also increased the planned average annual expense growth rates of the long-term care homes, community programs and other program areas over the same period.

- Planned expense growth for long-term care homes was increased from 2.3 per cent to 2.6 per cent.
- Planned expense growth for community programs was increased from 4.7 per cent to 5.1 per cent.
- Planned expense growth for other programs was increased from 0.7 per cent to 2.6 per cent.
- No significant additional funding was allocated to capital spending.

The 2017 budget also increased planned spending growth in the smaller health program areas



Source: FAO analysis of data from MOHLTC, TBS, the Public Accounts of Ontario, and the 2016 and 2017 Ontario Budgets.

⁸ Excluding the new funding for OHIP+, Ontario Drug Programs expense is forecast to grow by an annual average of 3.0 per cent over the 2015-16 to 2019-20 period.

4 | Health Care Cost Drivers and Health Sector Expense

The demand for health care services generally increases as the population grows and ages. At the same time, as prices rise with inflation, the cost of providing health care also increases. This chapter compares the 2017 budget plan for health sector expense to the FAO's forecast for health care cost drivers over the 2017-18 to 2019-20 period, and explores some possible implications for the Province's health sector budget in the coming years.

Health care cost drivers

Health care cost drivers put upward pressure on annual health sector expense. They include:

- **Population growth:** As the population grows, more people require health care services.
- **Population aging:** The average annual public health care expenditure for a 50-year-old in Ontario is \$3,000. It is \$6,500 for a 65-year-old, and over \$23,000 for an 85-year-old.⁹ Ontario's aging population will put increasing pressure on health care spending, as the large baby boom cohort begins to require significantly more health care services.¹⁰
- **Higher prices for health care services:** The FAO expects that consumer price inflation will average 1.9 per cent from 2017 to 2019. Since health care delivery is more labour intensive than other sectors of the economy, health care prices typically rise at a faster pace than overall consumer prices.¹¹
- **Health care enrichment:** Enrichment is the change in health care spending not accounted for by population growth, aging or inflation. Enrichment includes factors such as the introduction of new health care services (or the removal of old ones), the adoption of new technologies and medications, efficiency measures,

⁹ National Health Expenditure Trends, 1975 to 2016: Data Tables, Canadian Institute for Health Information, 2016.

¹⁰ See the FAO's [Long-Term Budget Outlook](#).

¹¹ See CIHI [Health Spending Data Tables](#), series B.

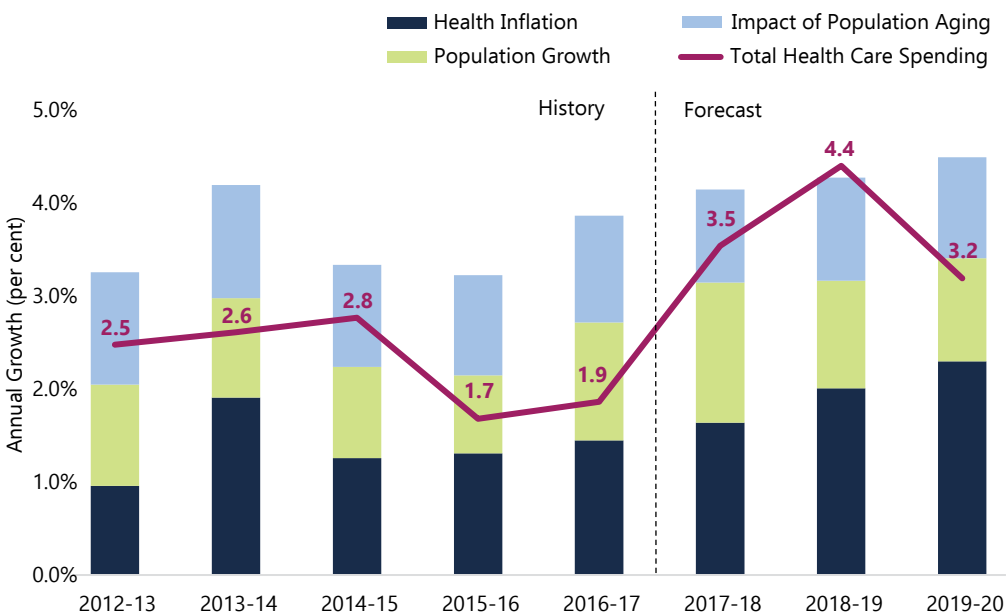
rising incomes, government policies, and the underlying health of the population, among other things.¹²

For analysis of health care cost drivers in the medium-term, the FAO focuses on the core cost drivers of population growth, population aging, and price inflation, but excludes the impact of enrichment, which is more difficult to fully quantify.¹³

Core cost drivers and health sector expense in the medium-term

From 2011-12 to 2016-17 annual Ontario health sector expense growth was well below core health care cost drivers. Additionally, even though the 2017 budget plan announced \$6.9 billion in new health sector spending from 2017-18 to 2019-20, health sector expense growth is only projected to out-pace the growth of core health care cost drivers in a single year – 2018-19.

Health spending is growing slower than its core cost drivers every year except 2018-19



Source: 2017 Ontario Economic Outlook and Fiscal Review, and FAO analysis of data from MOHLTC and TBS.

Over the planning period (2017-18 to 2019-20), the FAO projects that the core cost drivers of health spending will grow by an annual average of 4.3 per cent, while the

12 For example, if a new drug becomes available, health care enrichment would capture the expansion of the Ontario Drug Benefit Program to cover the increase in per capita prescription costs. See chapter 4 of the Ontario Ministry of Finance’s [“Toward 2025: Assessing Ontario’s Long-Term Outlook”](#) for a discussion of this topic.

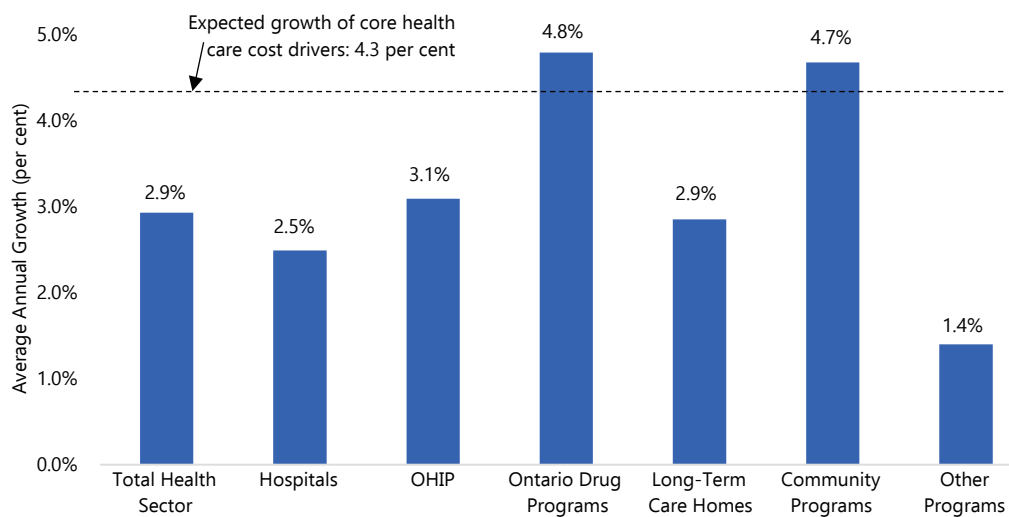
13 While the cost of new technologies or medications are known, other aspects of enrichment are more difficult to specifically estimate. In the long-term, the FAO assumes that governments will increase the growth of health care enrichment at a pace similar to its historical rate. See the FAO’s [Long-Term Budget Outlook](#).

Province plans to grow total health spending by an annual average of 3.7 per cent over the same period.

While this 3.7 per cent growth in total health spending is only somewhat below the growth of core health care cost drivers over the planning period, total health sector expense includes spending on new programs, such as OHIP+, and \$1.2 billion for a pension accounting adjustment, which will not directly relieve budget pressure in existing health services.¹⁴

To focus on existing health care services, the FAO removed funding for new initiatives (i.e. OHIP+) and the \$1.2 billion pension accounting adjustment from the 2017 budget's planned health sector spending. This reveals that the Province plans to grow spending for existing health care services by 2.9 per cent, which is well below the expected 4.3 per cent average rate of growth in core health care cost drivers over the planning period.

Spending growth for existing health services in most program areas will not keep pace with core health care cost drivers over the planning period (2017-18 to 2019-20)



Source: FAO and analysis of data from MOHLTC and TBS.

Excluding new initiatives and the \$1.2 billion pension accounting adjustment, the 2017 budget plan projects slower growth in most program areas than the projected growth of core health care cost drivers.¹⁵ Only Ontario Drug Programs and community programs are forecast to grow at a faster rate than overall core health care cost drivers from 2017-18 to 2019-20. Planned funding growth rates for

¹⁴ Indirectly, new health programs could enable better health outcomes or prevent problems, which could lower the use of other parts of the health care system.

¹⁵ Each program area may have unique cost drivers. For example, population aging may impact certain drug programs and long-term care homes more than other areas.

hospitals, OHIP, long-term care homes and other programs are all well below the 4.3 per cent growth rate of core cost drivers. In other words, funding increases for existing services in these program areas will not keep pace with the health care cost pressures associated with population growth, aging and price inflation.

How does the Province plan to continue restraining the growth of health spending to below its core cost drivers?

To slow health care spending growth to below its core cost drivers, there are a number of strategies jurisdictions can use including:

- improving the efficiency of health care service delivery;
- temporarily cutting planned spending (such as wage restraint or postponing maintenance); and
- reducing/rationing health care, eliminating select services, or allowing the quality of existing services to deteriorate.

The following identifies some important recent developments in Ontario's health sector that contributed to slowing expense growth since 2012-13, and analyzes how these measures could impact the health budget in the coming years.

Hospital efficiencies

Over a four-year period, from 2011-12 to 2015-16, the Province froze base operating funding for hospitals. At the same time, beginning in 2012, the Province introduced Health System Funding Reform for hospitals in an effort to increase the efficiency of hospital spending. This new funding model replaced a portion of hospitals' lump-sum operating funding with a "patient-based" funding model that allocates hospital operating funding based on a region's demographic factors and the complexity and type of care the hospital provides.¹⁶ The new funding model was phased in over three years.¹⁷

From 2012-13 to 2015-16, hospital funding restraint and funding reform resulted in the cost of a standard hospital stay in Ontario decreasing by 1.8 per cent while the national average increased by 5.4 per cent.¹⁸ According to the Ontario Hospital Association, these cost savings were achieved through efficiency gains, such as

¹⁶ Financial Accountability Office of Ontario, "Ontario Health Sector: Expense Trends and Medium-Term Outlook Analysis," Jan 2017.

¹⁷ Ontario Newsroom, "Moving to Patient-Based Funding Will Improve Care," 19 Mar, 2012.

¹⁸ Canadian Institute for Health Information. From 2012-13 to 2015-16 the cost of a standard hospital stay in Ontario decreased from \$5,462 to \$5,364 while the national average increased from \$5,786 to \$6,098.

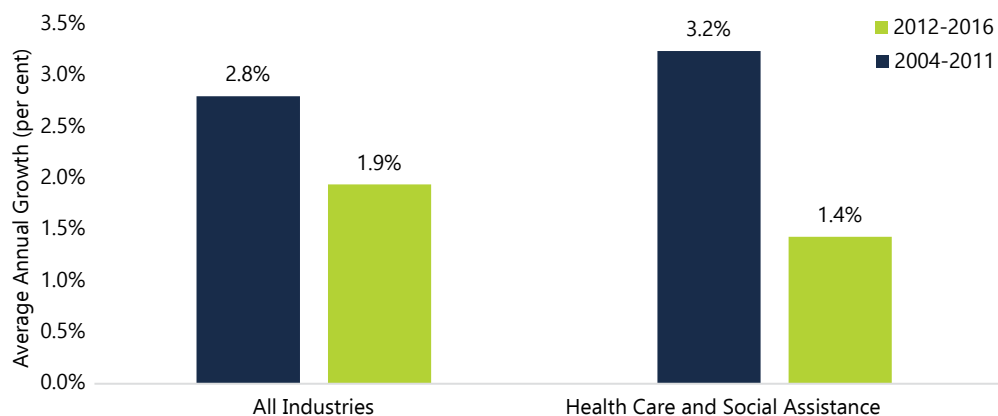
reducing the length of time patients stay in hospitals, as well as through temporary measures such as deferring hospital maintenance and equipment purchases.¹⁹ Restraining the wage growth of hospital workers also contributed to the cost savings.

Going forward, from 2017-18 to 2019-20, the Province plans to continue growing hospital spending more slowly than the growth of core health care cost drivers. This will require additional permanent efficiencies within the hospitals program area to avoid reductions in health care quality or access.

Health sector wage restraint

Since wages comprise the majority of health care costs, for OHIP and hospitals in particular, wage restraint has been an important aspect of slowing health sector expense. From 2004 to 2011, hourly wages in Ontario's broader health sector grew at a faster pace than the average for all industries. However, since 2012, hourly wages in Ontario's broader health sector have grown more slowly than the rest of the economy, and have not kept pace with price inflation.²⁰

Hourly wage growth in Ontario's health sector has been slow since 2012



Source: Statistics Canada Labour Force Survey, Table 282-0072.

The Province's actions to restrain physician fees was an important factor that slowed health sector expense growth from 2012-13 to 2016-17. The previous physician services agreement reduced service fees by 0.5 per cent in 2013. After the agreement expired, the Province cut physician fees by 2.65 per cent in February 2015 and a further 1.3 per cent in October 2015. The Province is currently negotiating with the Ontario Medical Association (OMA) on a new physician services agreement. As of March 2018, the Ontario Medical Association is entering binding arbitration with

¹⁹ Information provided to the FAO by the Ontario Hospital Association.

²⁰ While the Health Care and Social Assistance category (NAICS 62) includes more occupations than doctors and hospital workers, and does not reflect the Province's actual wage bill for the hospitals and OHIP program areas, doctors and hospital workers are captured within this category in the Labour Force Survey.

the Province, and the OMA has noted that a key priority is redressing the 2015 fee cuts. To the extent that physician fees are raised in the next agreement, it could put upward pressure on the OHIP program area's budget in the coming years.

Health care services: access and quality

With so many indicators of health care "quality", it is difficult to identify key trends, and to link these trends to recent health sector expense restraint. The FAO analyzed wait time data for major procedures since 2011 and surgeries since 2013, and found that 46% of wait times showed improvement, 40% showed deterioration and 14% remained constant.²¹ The FAO also analyzed emergency wait time data and found that overall, total time spent in the emergency room has decreased since 2011, but wait times have been increasing since 2015.²² Overall, the wait time data shows a mix of system improvements and deteriorations, however, there are also recent indications that hospitals are becoming overcrowded.²³

According to Health Quality Ontario, while "the big picture of health in Ontario looks good...timely access to care is an ongoing issue for patients in Ontario's health system."²⁴ For example, although most Ontarians receive high continuity of care (at least three-quarters of their visits are with the same doctor), only 44 per cent of Ontarians aged 18 or older report being able to get same day or next day appointments with their doctor.

Summary

Since 2012, a freeze in base operating funding to hospitals and wage restraint have been significant contributors in slowing health sector expense growth. Even with the additional health sector spending in the 2017 budget, hospital and OHIP program area spending is set to grow more slowly than their core cost drivers. It is not clear to what extent the Province can continue to rely on temporary measures (e.g. wage restraint) to achieve budget targets. Unless the Province can find significant efficiencies within the OHIP and hospital program areas, there is a fiscal risk that more spending will be required to avoid reductions in health care access or quality. In the years beyond 2019-20, budgetary issues in Ontario's health sector will only become more acute, as Ontario's growing and aging population will put additional upward pressure on health care costs over the long-term.²⁵

²¹ The data for wait times for major procedures can be found at <http://waittimes.cihi.ca>.

²² The ER wait times data can be found at <http://www.ontariowaittimes.com>. The wait times metric is the maximum amount of time in which 9 out of 10 ER patients have completed their visit.

²³ See the Auditor General's 2016 [Annual Report](#).

²⁴ Health Quality Ontario, "Measuring Up", 2017.

²⁵ See the FAO's [Long-term Budget Outlook](#).

5 | Federal Support for Ontario Health Spending

The Canada Health Transfer (CHT) is the largest federal transfer to the provinces and territories. The CHT provides funding for the purposes of maintaining the national criteria for publicly provided health care in Canada.²⁶ The CHT is also a major source of provincial revenue used to finance the Province's health sector expense.²⁷ In 2016-17, Ontario received a transfer of \$13.9 billion, which represented 24.9 per cent of the Province's total health sector expense.

From 2011-12 to 2016-17, Ontario health sector expense grew by an average annual rate of 2.3 per cent while the CHT allocation to Ontario grew by 6.0 per cent each year. As a result, from 2011-12 to 2016-17, 54 per cent of the growth in Ontario health sector expense was funded by increases to Ontario's CHT revenue, increasing the proportion of Ontario health sector expense financed by federal health transfers from 21.3 per cent in 2011-12 to 24.9 per cent in 2016-17.²⁸

Beginning in 2017-18, the funding formula for the CHT was changed to reflect the growth in Canada's nominal GDP.²⁹ Ontario will also receive \$4.2 billion in additional federal transfers over the next ten years for home care and mental health initiatives.³⁰ As a result, the growth rate of federal health transfers³¹ to Ontario will be reduced from 6.0 per cent to 4.5 per cent from 2017-18 to 2019-20.³² Importantly, since the Province plans to grow health spending by only 3.7 per cent over this period, federal health transfers will continue to fund an increasing share of the Province's health sector expense, rising from 24.9 per cent in 2017-18 to 25.4 per cent by 2019-20.

26 Government of Canada. "Canada Health Act Annual Report 2015-2016." Feb 2017.

27 Provinces are not obliged to spend CHT transfers on health care, however, they are required to comply with the Canada Health Act to receive the CHT.

28 In 2011-12, Ontario health spending was \$50 billion and the CHT funded \$10.7 billion. In 2016-17, Ontario health spending was \$56 billion (an increase of \$6 billion) and the CHT funded \$13.9 billion (an increase of \$3.2 billion). Therefore, the CHT funded \$3.2 billion of the \$6 billion increase in health sector expense in 2016-17. In other words, 54% of health sector expense growth was funded by growth in Ontario's CHT revenue.

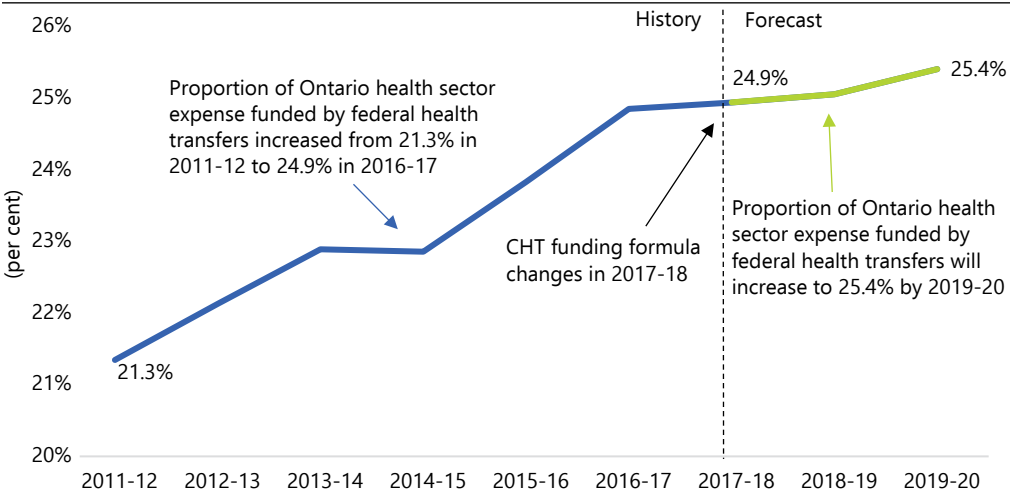
29 The CHT will grow in line with the three-year moving average of Canada's nominal GDP, with a minimum growth rate of 3.0 per cent.

30 Health Canada. "Canada Reaches Health Funding Agreement with Ontario." 10 Mar. 2017.

31 "Federal health transfers" refers to CHT plus home care and mental health funding.

32 This is a combination of projected CHT growth of 3.5% and 1.0% growth due to home and mental health funding.

Share of Ontario health sector expense funded by federal health transfers will continue to increase



Source: FAO and analysis of data from MOHLTC and TBS.

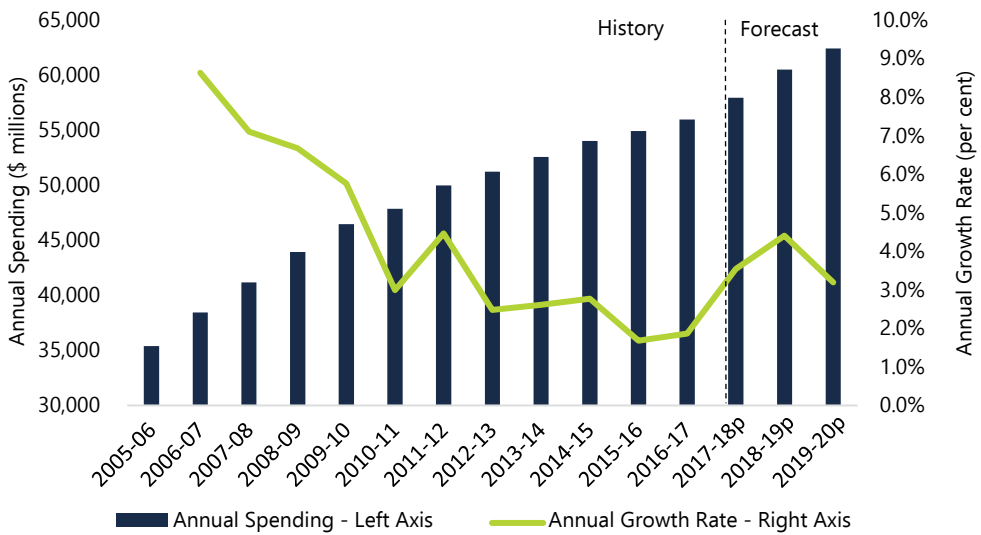
Beyond 2019-20, the FAO projects that federal health transfers will grow by 3.8 per cent annually over the long-term³³ under the current funding formula.³⁴ The FAO also projects that Ontario’s health care cost drivers will grow by an annual average of 4.8 per cent over the long-term.³⁵ Therefore, under the new CHT funding formula, the growth of federal health transfers will not keep pace with the anticipated upward pressure of health care cost drivers on health sector expense.

33 This is in line with the FAO’s projection of Canada’s long-term nominal GDP growth.
 34 The FAO also assumes that federal funding for home care and mental health will continue indefinitely.
 35 For a discussion of the FAO’s projection for the long-term growth of health care cost drivers see the FAO’s [Long-Term Budget Outlook](#).

6 | Appendices

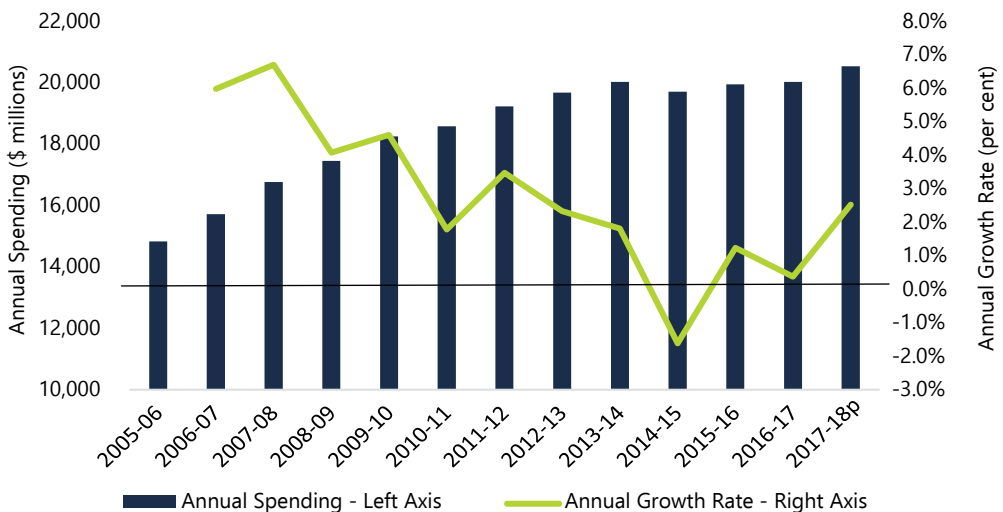
Appendix A: Ontario health sector expense data by program area

Chart A-1: Total health sector expense and annual growth rate



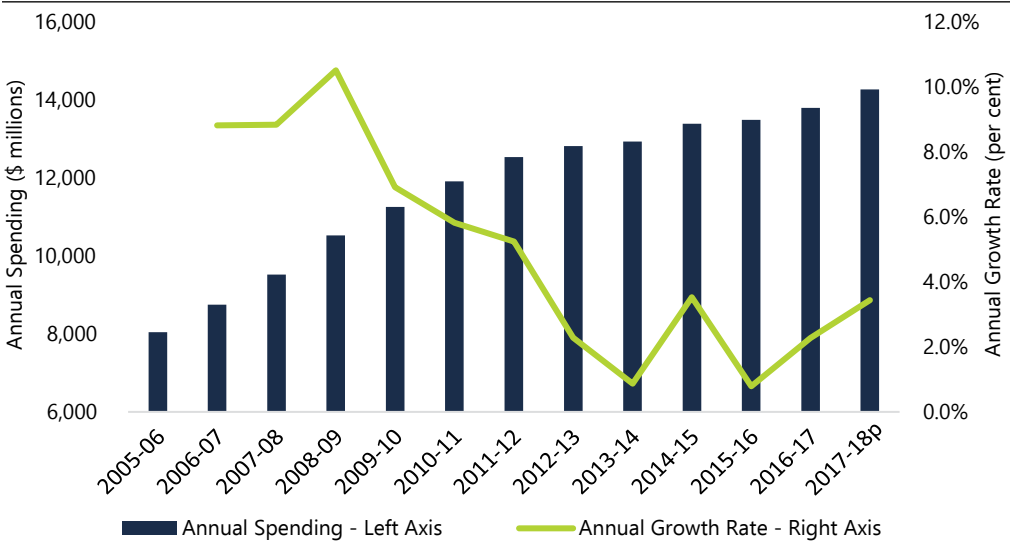
Source: FAO analysis of data provided by MOHLTC and TBS.

Chart A-2: Hospitals expense and annual growth rate



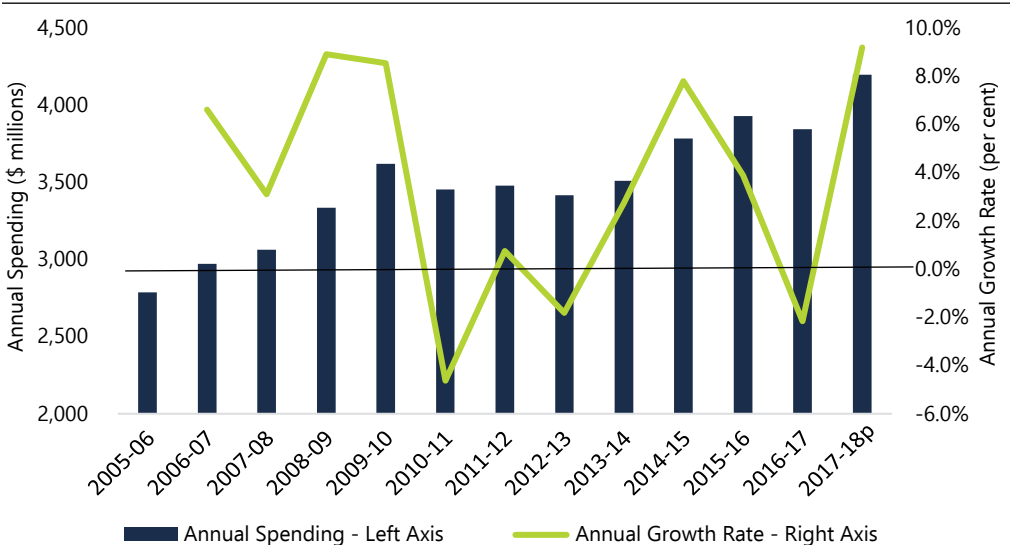
Source: FAO analysis of data provided by MOHLTC and TBS.

Chart A-3: OHIP expense and annual growth rate



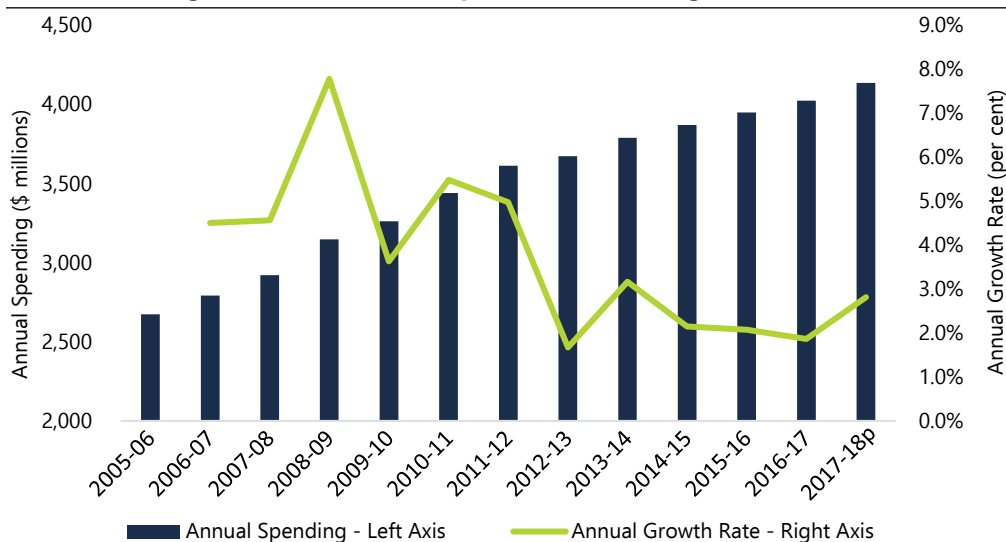
Source: FAO analysis of data provided by MOHLTC and TBS.

Chart A-4: Ontario Drug Programs expense and annual growth rate



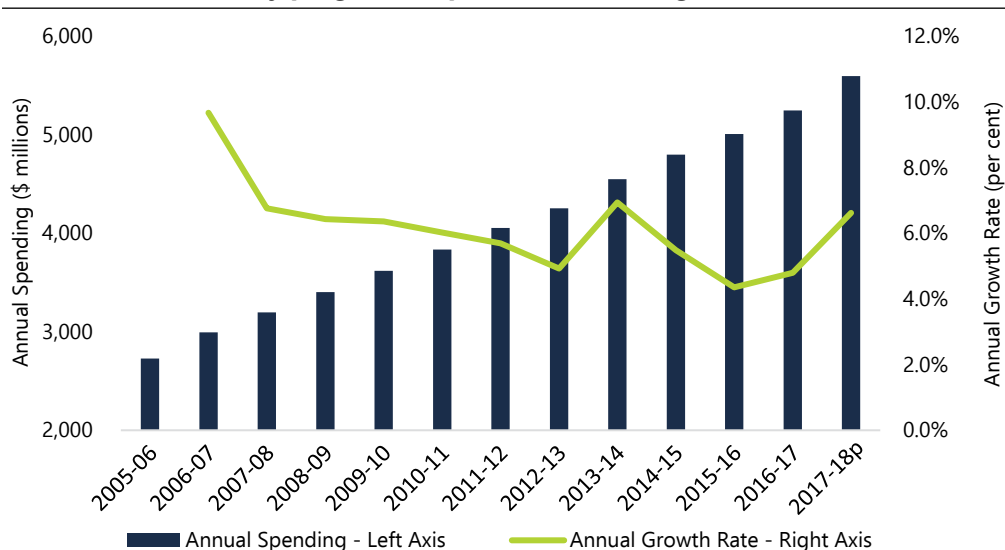
Source: FAO analysis of data provided by MOHLTC and TBS.

Chart A-5: Long-term care homes expense and annual growth rate



Source: FAO analysis of data provided by MOHLTC and TBS.

Chart A-6: Community programs expense and annual growth rate



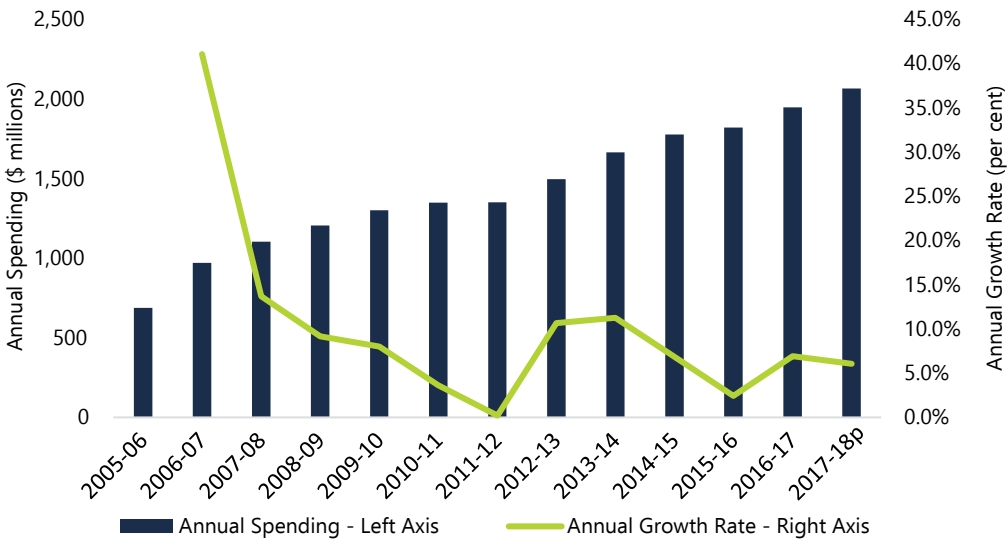
Source: FAO analysis of data provided by MOHLTC and TBS.

Chart A-7: Other programs expense and annual growth rate



Source: FAO analysis of data provided by MOHLTC and TBS.

Chart A-8: Capital expense and annual growth rate



Source: FAO analysis of data provided by MOHLTC and TBS.

Appendix B: Development of this report

Authority

The Financial Accountability Officer decided to undertake the analysis presented in this report under paragraph 10(1)(a) of the *Financial Accountability Officer Act, 2013*.

Key questions

The following key questions were used as a guide while undertaking research for this report:

- How will the additional \$7 billion investment in health sector expense affect health sector program area growth rates?
 - What are the medium-term growth rates of health sector expense by program area?
 - What program changes will result from the increased funding?
 - How has the Canada Health Transfer affected health sector funding?
 - How do the planned program changes resulting from the increased funding compare to the FAO's projections of long-term health spending drivers?

Methodology

This report has been prepared with the benefit of information provided by, and meetings with staff from, the Ministry of Health and Long-Term Care, Treasury Board Secretariat and the Ministry of Finance, and a review of relevant literature and other publicly available information. Specific sources are referenced throughout.

All dollar amounts are in Canadian current dollars (i.e. not adjusted for inflation) unless otherwise noted.